Abstracting Stroke Workshop Toolkit

Published November 2017

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Overview

Ensuring the quality of a hospitals stroke data is essential to its credibility and value. Stroke abstractors range from novice to expert. The need for a training program focused on abstracting a mock record was recognized by the Wisconsin (WI) Coverdell Stroke Program and the American Heart Association (AHA). The developed biannual training workshop fosters networking and provides the opportunity to discuss the Get With the Guidelines ® - Stroke PMT® (GWTGs). This educational and training opportunity is titled "Abstracting Stroke Data That Will Work For You." The training assists the participants in understanding the GWTGs Coding Instructions, and provides a non-threatening learning environment to discuss difficult to interpret data elements.

Acknowledgements

Use or replication of any documents in this toolkit must include the Wisconsin Coverdell Stroke Program and AHA logos. In efforts to demonstrate scalability, all evaluation results must be shared with the WI Coverdell Stroke Program and AHA. Please send all completed pre and post tests to lynn.serdynski@heart.org.

A special thank you to the Georgia Coverdell Acute Stroke Registry for sharing the original mock stroke chart.

Contributors to the content and production of this tool kit include:

- Jessica Link, Coverdell Program Director, Department of Health Services
- Dot Bluma, BSN, RN, CPHQ Stroke Project Specialist, MetaStar, Inc.
- Lynn Mallas-Serdynski, RN, BSN, Director of Quality and Systems Improvement, Wisconsin Midwest Affiliate

Before the Event

When sending registration to your distribution list, request of the participants to self-identify their level of GWTG abstraction proficiency. We use novice, competent, expert. Provide for round tables with capacity for seating of four. To ensure networking opportunities, use the information attained from the self-identified abstraction proficiency to assist in arranging the tables with a mix of capabilities from different hospitals.

We have found assembling conference documents in a three-ring binder for participants to take with them is optimal. We include the current paper GWTGs PMT for abstracting the mock chart, or the on-line GWTG PMT can be utilized as well. Having several copies of the Coding Instructions available for participants to reference has been beneficial during the mock chart abstraction.

Workshop Binder

The agenda is always sent in advance, and is included in the participant's binder. See page five for a sample agenda.

An evaluation of pre-session and post-session understanding must be obtained to measure changes in confidence in performing specific tasks in GWTG. Ensure the pre-session surveys are collected immediately upon completion. This will safeguard participants from having access to their pre-survey responses when completing the post-session survey. See pages six and seven for sample surveys.

The mock chart is available on pages nine-seventeen. Be aware, as abstraction guidelines change, the mock chart must be updated to reflect these. The mock chart included was utilized November 2017.

Abstracting Stroke Data That Will Work For You

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Time	Presentation Title	Faculty
7:30 AM – 8:00 AM	**Breakfast/Registration**	
8:00 AM - 8:15 AM	**Welcome, Introductions and Overview of Program** **Pre-Session Survey**	Dot Bluma, BSN, RN, CPHQ Stroke Project Specialist MetaStar, Inc Lynn Mallas-Serdynski,BSN, RN Quality & Systems Improvement Director American Heart Association
8:15 AM – 10:45 AM	**Making Sense of Get With the Guidelines Stroke Data Elements**	
8:15 AM - 9:15 AM	**Mock Chart Abstraction**	Attendees will divide into groups of 3-4 to complete a mock chart abstraction
9:15 AM – 10:45 AM	**Review Results of Mock Chart Abstraction & Highlight difficult to abstract data elements**	Lynn Mallas-Serdynski, BSN, RN, Quality & Systems Improvement Director American Heart Association
10:45 AM -11:00 AM	**Break**	
11:00 AM - 11:15 AM	**Using Your Configurable Measures Reports**	Lynn Mallas-Serdynski, BSN, RN, Quality & Systems Improvement Director American Heart Association
11:15 AM-12:15 PM	**Making Your Get With the Guidelines-Stroke Data Meaningful**	Dot Bluma, BSN, RN, CPHQ Stroke Project Specialist MetaStar, Inc
12:15 PM-12:30 PM	**Wrap-Up/Closing Comments** **Post-Session Survey**	Dot Bluma, BSN, RN, CPHQ Stroke Project Specialist MetaStar, Inc Lynn Mallas-Serdynski, BSN, RN, Quality & Systems Improvement Director American Heart Association

This document was created for the WI Coverdell Stroke Program and American Heart Association and the logos must remain. To demonstrate scalability, all evaluation results must be shared with the WI Coverdell Stroke Program and American Heart Association.

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Abstracting Stroke Data That Will Work For You
Get With The Guidelines Stroke® Training <u>Pre-session</u> Survey
Date_____ Location_____

The purpose of this survey is to assess your level of confidence, both before and after the training, in: Understanding how to utilize the coding instructions; entering stroke data; formatting, performing, and interpreting data downloads, and run configurable measures reports from the Get With the Guidelines® (GWTG) program.

Please choose the response that best describes your <u>level of confidence</u> for each of the following GWTG functions.	**Not at all confident**	**Not very confident**	**Somewhat confident**	**Very confident**
1. Fully understand the GWTG's coding instructions	☐	☐	☐	☐
2. Entering data accurately	☐	☐	☐	☐
3. Downloading data from the database	☐	☐	☐	☐
4. Interpreting the meaning of downloaded data elements	☐	☐	☐	☐
5. Running configurable measures reports to identify areas of process improvement	☐	☐	☐	☐
6. Using data results to identify areas needing change	☐	☐	☐	☐

The following information is needed to help us match your pre-session survey to your post-session survey, which will be administered at the end of this session. Thanks for helping by providing this information!

What is the number of the month in which you were born? (Ex: May = 05) _____

What are the last two numbers of your Social Security number? _____

How many sisters do you have? _____

Insert your logo here

Abstracting Stroke Data That Will Work For You
Get With The Guidelines Stroke® Training Post-session Survey
Date_____ Location_____

The purpose of this survey is to assess your level of confidence, both before and after the training, in: Understanding how to utilize the coding instructions; entering stroke data; formatting, performing, and interpreting data downloads, and run configurable measures reports from the Get With the Guidelines® (GWTG) program.

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Abstraction Chart Index

Abstraction Chart Sample

SECTION 1:

Account # 2211
Arrival date – 04/01/2017 @ 15:00
Admission time –04/01/2017 @ 17:00
Name – Tammy Polly Anderson
Sex – Female
Race – African American
Date of birth – 3/15/1955
Height: 5'4", Weight: 90.70kg
Social Security # - 666-44-1111
Insurance – United HealthCare of WI
MDC: 01 Diseases/Disorders of the nervous system
DRG: 014 intracranial hemorrhage or cerebral infarction

Diagnoses Description
I63.50 CRBL ART OCL NOS W INFRC
R47.01 APHASIA
CM I10HYPERTENSION NOS

GENERAL PATIENT INFORMATION:
Language you feel more comfortable with –English
Reason for admission/chief complaint as stated by patient or others – disorientation, weakness, altered mental status, aphasia
Does the patient have an advance directive – DNR/DNI
Tobacco use – quit 3 months ago
Caffeine use – no
History of alcohol use – no
History of street/recreational drug use – no

REVIEW OF SYSTEMS:
Cardiac – cardiac problems – yes
    Cardiac conditions/symptoms – hypertension, history of carotid stenosis
Neurological – neurological problems – yes
    Neurological problems – weakness/paresis
    Communication problems – yes
Communication problems present – aphasic selective
Musculoskeletal problems – no
Endocrine – Endocrine problems – no

SECTION 2:

EMERGENCY ROOM REPORT
Arrived at ED 04/01/2017 @ 15:00
Last Known Well: 04/01/2017 @ 1415

History & Physical Information:
The patient is a 62 year old female who presents with a complaint of speech difficulty and dizziness. Patient arrived via EMS, who transported from Southridge mall. EMS called ED via radio at 14:30 stating potential stroke patient with AMS and weakness. Currently having difficulty speaking, weakness/dizziness occurred at 14:15 as witnessed by daughter when shopping. Daughter reports that patient suddenly had difficulty speaking in changing room while trying on clothes and then could not raise right arm. Daughter thought patient was dizzy and suggested that she sit down and then called 911.

ROS:
Constitutional: negative for fever, negative for chills
Eyes: positive for blurred vision, negative for diplopia, negative for visual field defect
Cardiovascular: negative for chest pain, negative for palpitations, negative for diaphoresis, negative for dyspnea, negative for SOB at rest, negative for SOB on exertion, negative for syncope, negative for tachycardia
Respiratory: negative for cough, negative for dyspnea, negative for wheezing, negative for dyspnea on exertion, negative for stridor, negative for tachypnea
Gastrointestinal: negative for nausea, negative for vomiting, negative for abdominal pain
Musculoskeletal: negative for arthralgias, negative for arthritis, negative for back pain, negative for injury, negative for neck pain, negative for redness
Neuro: positive for headache, positive for confusion, positive for weakness, negative for numbness, positive for altered level of consciousness, positive for aphasia, positive for difficulty walking, positive for disorientation.

PHYSICAL EXAMINATION:
Vital sign: BP 175/100, heart rate 100, respiration 12, and temperature is 96.7 degrees, and saturation is 95% room air.
Constitutional: disoriented, confused, unable to raise right arm
Eyes: sclera clear, no icterus, Pupils equal, round and reactive to light accommodation
Neck: supple
Cardiovascular*:* S1/S2, no S3, no S4 irregular, no murmurs, no rubs or gallops
Respiratory: breath sounds clear and equal bilaterally, no rales, rhonchi, or wheezes, normal respiratory effort/exertion
Chest: non-tender, no chest deformity, movement normal, movement symmetrical
Neuro: cranial nerves II-XII, difficulty finding and pronouncing words, abnormalities on NIHSS record, motor difficulty in right upper and lower extremities, left upper and lower extremity normal strength, gait abnormal – unable to ambulate.
Head & face: face atraumatic, head atraumatic, normocephalic
Abdomen/GI: soft, non-tender, with normal bowel sounds, no distention
Extremities: No cyanosis, clubbing or edema

MEDICAL DECISION MAKING:
Differential diagnosis: complicated migraine, partial seizures, hypertensive emergency, stroke, nerve compression, peripheral neuropathy, radiculopathy, subarachnoid hemorrhage, transient ischemic attack

Diagnostic evaluation in ER: history and physical examination, x-rays, 12 lead ECG, BMP/CMP, CBC, cardiac enzymes, CT head

LAB/RAD:
Cranial CT SCAN-
History = disoriented, right side weakness, dizziness, slurred speech
Images are obtained from the skull base to the vertex without contrast.

There is mild atrophy. The ventricular system is normal. There is a subtle hypodensity in the region of the caudate nucleus on the left. No hemorrhage or mass effect. This likely represents a remote small lacunar infarct. No extra-axial fluid collections.
IMPRESSIONS: REMOTE LEFT CAUDATE NUCLEUS INFARCT. NO HEMORRHAGE
Preliminary Read Completed 04/01/2017 @ 15:15. Time Resulted 04/01/2017 @ 15:20

Lab Results: 04/01/2017 @ 15:42

WBC Result	5.8
RBC	4.68
Hemoglobin	15.0
Hematocrit	45.6
Platelet Count	285
Blood Glucose	101
BUN	20
Creatinine Blood	1.1
Sodium Blood	135
Potassium Blood	4.2
Chloride Blood	108
CO2	22
Calcium Blood	9.3
Protein Total Serum	7.4
Albumin Blood	4.4
AST	22
ALT	21
Alkaline Phosphatase	75
Bilirubin Total	1.3
AGap	9
BUN/Creat Ratio	21
PT Seconds	13.2
INR	0.8
PTT	32.1
Sedimentation Rate	3
Cholesterol Blood	236
Triglycerides Blood	154
HDL Cholesterol	31
LDL Cholesterol	85
HG A1C	5.4

Interpretation of laboratory tests: normal WBC, normal hemoglobin, normal hematocrit, normal platelets, normal glucose (serum) normal sodium (serum), normal potassium, normal HCO3, normal BUN, normal creatintine, normal AST, normal ALT, normal bilirubin, normal alk phos, normal albumin, normal INR, normal PT, normal PTT

CT head: impression – remote left caudate nucleus infarct. No hemorrhage

Chest X-ray – PA and lateral chest – conclusion – No acute finding.

EKG interpretation: cardiac rhythm – normal sinus rhythm. EKG interpretation – nonspecific ST T wave changes

REASSESSMENT: patient prepared for treatment.

Fall risk assessment: high fall risk because non-ambulatory, disoriented, weakness

Swallow screen 04/01/2017 @ 15:26 Failed Swallow screen
Patient to be kept NPO until determination of treatment

Neuro

Reflexes and strengths – grip unequal bilaterally
Reflexes and strengths – moves left extremities well, unable to move right side
Reflexes and strengths- lower extremity strength unequal

Systolic: 175
Diastolic: 100
Pulse rate: 100
Respirations: 16
Rhythm: irregular
Pulse oximetry %: 99

Plan of Care:
Administer Alteplase after further history obtained. Evaluate stroke symptoms as specified by care map.
Daughter arrived @ 15:10 and stated the following:

- No history of seizure, recent surgery or trauma, no family history of stroke that she knows of
- States that patient is a DNR/DNI and has an advanced directive filed with her PCP
- States that patient takes Zocor 20mg daily
- Also states that she quit smoking 3 months ago
- Admit to stroke ICU unit for care.

Plan of care discussed with daughter. Daughter consented to Alteplase treatment plan and expressed understanding of plan of care.

Patient RX Profile
Allergies: NKDA, No Known Drug Allergies
Home Medications as obtained from daughter:

- Aspirin 81mg Daily
- Zocor 20mg Daily

Daughter states that patient also takes over the counter vitamins.

SECTION 3:

HISTORY & PHYSICAL

PROBLEM LIST:

Primary reason for admission is acute cerebrovascular accident
Elevated Blood pressure

History of present illness: The patient is a 62 year old African American female, who is here today because she became disoriented, weak, unable to form words while shopping as witnessed by her daughter. She developed other complaints of paralysis, numbness, weakness, and headaches after arrival to the ED. The patient came to the emergency room, where a CAT scan of the head was done. The CAT scan of the head showed a remote cerebrovascular accident in the left caudate nucleus. There is no hemorrhage. The patient received Alteplase and will now be admitted to the hospital. Findings discussed with neurologist.
Social history: Quit smoking 3 months ago, no history of alcohol and no history of recreational drug use, patient is widowed; lives with daughter and 2 grandchildren.
Family history: no known history for coronary artery disease, stroke and diabetes in family.
Physical Examination:
Vital signs: the patient's blood pressure is 175/100, heart rate 52, respiration 12, temperature is 96.7 degrees, and saturation is 95% room air.
NIH Stroke Scale: Of 14 completed in the ED after alteplase infusing
HEENT: head is normocephalic, atraumatic. Eyes: pupils are equal, round, and reactive to light and accommodation. Ears are clear. Mouth is clear. Throat is clear. Noted patient complain of being thirsty and nurse gave patient ice chips in the ED 04/01/17 @ 15:21.
NECK: No carotid bruits are appreciated. No palpable masses.
LUNGS: No rales or crackles.
HEART: Rapid rate and irregular rhythm, no murmurs, rubs, or gallops. Distant heart sounds are appreciated in the apex, actually in the base of the thorax.
ABDOMEN: No palpable masses. No obvious organomegaly. Positive bowel sounds. No palpable abdominal aorta. No hernias.
EXTREMITIES: No edema, no cyanosis or clubbing.
VASCULAR: Examination shows decreased pulses, dorsalis pedis and posterior tibials. At present, the popliteals and femorals are equal and symmetric.
NEUROLOGIC: The patient is disoriented and varying levels of consciousness with marked decrease in level occurring. Subtle expressive aphasis is noted on examination. Tongue is midline. Neck is supple. Gait was not examined.
CT RESULTS: CT scan of the head shows a remote stroke in the left caudate nucleus. There is no evidence of hemorrhage or mass effect. There are no tumors appreciated.
PLAN: The case has been discussed with neurologist, and agreement exists for management at the present time. IV Alteplase will be administered (Alteplase Bolus Dose 8.1mg over 1 minute) Infusion Dose: 72.9mg over 60 minutes. Administered 04/01/2017 @ 15:45. Neurological assessment and vital signs (except temperature) every 15 min during rtPA infusion, then every 30 min for 6 h, then every 60 min for 16 h (total of 24 h) Note: Frequency of BP assessments may need to be increased if systolic BP stays _180 mm Hg or diastolic BP stays _105 mm Hg. Temperature every 4 h or as required. Treat temperatures _99.6°F with acetaminophen as orderedA stroke workup will be ordered, which will include magnetic resonance imaging/magnetic resonance angiography of the brain, magnetic resonance angiography of the neck, echocardiogram, bilateral carotid dopplers, lipid profile, and cardiac isoenzymes to rule out myocardial ischemia when patient stable.

ECG:

Interpretation: ATRIAL FLUTTER VARIABLE A-V BLOCK, VENTRICULAR RATE OF 100.
LEFT ANTERIOR FASCICULAR BLOCK
NONSPECIFIC ST AND T WAVE ABNORMALITY
ABNORMAL ECG

MRA HEAD WITHOUT CONTRAST

HISTORY– 62 YEAR OLD WITH IV ALTEPLASE ADMINISTRATION. HYPERTENSION

TECHNIQUE – NONCONTRAST 3D TIME-OFFLIGHT MRA OF THE INTRACRANIAL VESSELS PERFORMED.
FINDINGS: There is no flow gap to suggest major vessel occlusion. However there is mild luminal irregularity at the MCA bifurcation bilaterally and posterior cerebral arteries bilaterally felt to be related to intracranial atherosclerosis. Anterior communicating artery is patent and appears normal. There is no aneurysm identified. Normal flow signal is otherwise present within the major intracranial vessels making of the Circle of Willis.
IMPRESSIONS:

1. No significant intracranial stenosis
2. Intracranial arthrosclerosis involving MCA and PCA branches.

MRI BRAIN WITHOUT CONTRAST
HISTORY: 62 year old ISCHEMIC STROKE. Hypertension
TECHNIQUE: routine noncontrast MRI brain
FINDINGS: there is a focal area of abnormal signalintensity centered in the left basilar ganglia extending to the conrona rediata. T2 hyperintensity region measures up to approximately 1.5 cm in diameter. There is restricted diffusion of this area. Findings are consistent with acute infarction. This area is relatively to slightly hypointense on T1 weighted images. There is minimal mass effect on the left lateral ventricle. There is no hemorrhage or significant edema surrounding it. Ventricles are within normal limits. Remote lacunar infarction is demonstrated in the posterior limb of the left internal capsule. There is no midline shift or extraaxial fluid collection. Normal flow signal is demonstrated within the major intracranial vessels and venous sinuses. Mucous retention cysts are demonstrated within the maxillary sinuses bilaterally. There is also mild opacification of the sphenoid, ethmoid and frontal sinuses. There are no air fluid levels.
IMPRESSIONS:

1. Acute infarction within the left ventricular stripe region.
2. Remote lacunar infarction in the posterior limb of the left internal capsule.
3. Chronic paranasal sinus disease

PA AND LATERAL CHEST:
The heart is normal in size with left ventricular configuration. Pulmonary vascularity is within normal limits. The osseous structures are unremarkable. Mild aortic elongation is noted.
CONCLUSION: MILD DIFFUSE, INTERSTITIAL PROMINENCE

ECHOCARDIOGRAM
Left ventricular chamber size is normal. Septal motion is paradoxical. The rest of the ventricle contracts well. The ejection fraction appears to be 40 – 45%. The left atrium is moderately dilated. The right ventricular chamber size and systolic function are within normal limits. There is moderate dilation of the aortic root, measuring 4.33cm. Bubble study was performed which was negative for PFO.

CAROTID DUPLEX SCAN BILLET:
CONCLUSIONS: there is less than 40% stenosis in the right internal carotid artery. The right vertebral artery is patent with antegrade flow. There is less than 55% stenosis in the left internal carotid artery. The left vertebral artery is patent with antegrade flow. Left ICA tortuosity noted.
HISTORY: hypertension.

SECTION 4:

Cardiology Consultation Report – performed 04/02/2017 @ 16:21
62 year old female admitted 04/01/2017 with ischemic stroke Pt. was found to have a remote CVA in L caudate nucleus with an acute infarct in the left ventricular strip region. Pt. was noted to be in atrial flutter with VR. Newly diagnosed atrial flutter with rate 100 – 120 on telemetry.

CAD – H/O Left Heart Cath 12/29/05 – Dr. Penumbra. EF 50-55%. RCA with 65% lesion and mild diffuse disease distally. LAD 30-40% lesion. Right dominant

BP 155/90
HR 100 – 120
HTN

Neurology Consult performed 04/02/2017 @ 08:45:
Asked to see patient for acute stroke. Patients LKW 04/01/2017 @ 1415 as reported by daughter. . Disorientation, weakness, varying levels of consciousness, vertigo, N/T facial droop, balance issues. Left internal capsule infarct noted on MRI. Patient also found to have new onset a fib/flutter.

Previous Medical History: HTN
Family History: No CVA/TIA
Medications: ASA, Zocor
ECHO done but pending
MRI Brain: Acute infarct left basal ganglia, minimal mass effect.
MRA Head: Intracranial atherosclerosis in MCA/PCA branches bil
IMP: Acute stroke left basal ganglia CVA causing isolated expressive aphasia. New onset atrial fibrillation, TTE pending, carotid U/S. Ischemic stroke presumably due to atherosclerosis in MCA with possible cardioembolic source due to new onset a.fib.
us DVT Prophylaxis: Lovenox 100mg Subcutaneously every 12 hrs x 6 doses (first dose administered 04/02/2017 @ 09:30)
Expect good recovery
Need long term anticoagulation
Recommend: Coumadin
Rehabilitation therapy request

THERAPY EVALUATION performed 04/02/2017 @ 09:15:
Orientation to person, place & time.
Level of consciousness – altered level of consciousness on 04/01/2017 but states that improved from yesterday
Follows commands and answers questions – 50% of time; unable to follow multi-step instructions; able to follow single step instructions
Personal safety/judgment – variable
Sequencing – WFL
Range of motion – evaluate at later date
Strength – evaluate at later date
Independent functional performance in the following:
None at this time
Functional Status prior to admission: Independent not requiring any assistive devices

Problems identified which require skilled intervention. Plan of care to be developed. Probable discharge to rehabilitation unit.

EDUCATION RECORD
Individualized goals:
Patient unable to perform on 04/02/2017
Final goals are:

State the signs and symptoms of common potential complications and the appropriate action to be taken – review and reinforce
State the name, purpose, dosage, route, scheduling, potential food/herb/drug interaction, major side effects, importance of taking medications and impact of missing medications – review and reinforce
Demonstrate/state safe and effective use of medical equipment and supplies – review and reinforce
State physiology of pain and pain management treatment plan/options – review and reinforce
Identify risk factors for recurrent stroke and state plans to minimize these risk factors – review and reinforce
Identify safety measures to be taken with day-to-day activities (positioning, mobility, aspiration precautions, and use of assistive devices) – review and reinforce
04/03/2017 Patient and daughter are counseled on smoking cessation; and received education and resource materials on warning signs and symptoms of stroke, and activation of the emergency medical system (EMS) if signs or symptoms of stroke occur. Reviewed safety measures while on heparin and coumadin and to notify hospital if any bleeding noted.

SECTION 5:

DISCHARGE SUMMARY

62 year old female came into the emergency room with right paralysis, aphasia, headache, and no palpitations. VITAL SIGNS: revealed a blood pressure of 175/100. Head, eyes, nose and throat examination normal. Neck – supple. Chest – clear. Cardiovascular – irregular rate without murmur, gallop, rub or click. Abdomen – benign. Musculoskeletal – normal. Neurologic examination abnormal. CT scan showed remote stroke in the left caudate nucleus. No hemorrhage or mass effect. CBC and CMP were normal. The patient was diagnosed with an ischemic infarct in the left ventricular strip. She also had new onset atrial fibrillation.
HOSPITAL COURSE – She was seen in consultation by neurology and cardiology. She received thrombolytic medication via IV route and had no complications. Patient will be released to acute rehabilitation program for continuation of treatment. Patient with limited mobility, requiring contact guard by 2 to assist with ambulation; expressive aphasia improving; following one step commands 75% of the time. Tolerating a puree diet.
DISCHARGE MEDICATIONS: Zocor 80 milligrams a day, Cozaar 25 milligrams a day, Coumadin 2 milligrams daily
DISCHARGED V/S: 99.2-88-16-144/92
DISCHARGE NIHSS: 6 RANKIN SCORE: 4

DISCHARGE INSTRUCTIONS

Date: 04/05/2017 Time: 11:00
Discharge diagnosis: Cerebral Artery Occlusion with Infarction
General Information
INT/Telemetry Removed Yes
Discharged via: Stretcher
Who will help care for you following discharge? Daughter
Personal belongings returned: None
Discharged: IRF for minimum of 2 weeks.

Prescription at Discharge None	Dose	Schedule	Last Dose Given at	Purpose/Special Instructions
Coumadin	2 mg	daily		
Cozaar	25 mg	1daily		
Zocor	80 mg	1 daily		

DISCHARGE MEDICATION SUMMARY

DO NOT TAKE any medications except those listed below without first contacting your physician.

DO NOT TAKE AFTER DISCHARGE PER PHYSICIAN	TAKE AFTER DISCHARGE PER PHYSICIAN	NEXT DOSE DUE	ACTIVE MEDICATIONS	COMMENTS
			Losartan Potassium 25 mg Tabs Cozaar 25 mg by mouth once a day	This is for your blood pressure
			Simvastatin 80 mg tabs Zocor 80mg by mouth at bedtime	This is your cholesterol lowering medication
			Warafin sodium 2 mg tab Coumadin 2 mg by mouth daily	This is to prevent blood clots